COMMUNITY HOMELESSNESS ASSESSMENT, LOCAL EDUCATION AND NETWORKING GROUPS (CHALENG) FOR VETERANS

THE NINTH ANNUAL PROGRESS REPORT ON PUBLIC LAW 105-114

SERVICES FOR HOMELESS VETERANS ASSESSMENT AND COORDINATION

March 4, 2003

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FY 2002 Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Veterans Report

Executive Summary

Since 1993, the Department of Veterans Affairs (VA) has collaborated with local communities across the United States in Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans. The mission of CHALENG is to empower local communities to help homeless veterans regain their health (mental and physical), re-build meaningful interpersonal relationships (including family reunification), secure employment and stable housing, and ultimately return to society as productive citizens.

As in previous years, data collected during the FY 2002 CHALENG process – mainly from questionnaires completed by VA staff, local government officials, community providers, and homeless veterans themselves – are reported here. The following are highlights of the FY 2002 CHALENG report:

- Participation remains high.

  There were 3,451 respondents to the FY 2002 Participant Survey. About 39% of the respondents had personally participated in CHALENG for at least two years; almost two-thirds (63%) of the agencies they represented had been involved with CHALENG for at least two years.

- Need priorities remains consistent.

  - As in the past four years, long-term housing, dental care, eye care, and child care remained the top unmet needs reported by community, VA, and homeless veteran respondents in FY 2002.
  - The estimated number of homeless veterans across sites reported by the CHALENG Point of Contacts ("POCs," usually local VA homeless program coordinators) is 299,321.
  - CHALENG POCs estimated a need for an additional 14,406 emergency beds, an additional 13,523 transitional beds, and an additional 19,934 permanent beds for the housing of homeless veterans nationwide.

- VA/community partnerships continue to develop.

  - There are indications that implementation of concrete VA/community partnership activities such as developing interagency agreements and shared client tracking systems increased between FY 2001 and FY 2002.
  - VA staff participated in 81% of all available local homeless coalition meetings.
  - 312 new interagency agreements between VA and community agencies were developed in FY 2002.

    - 403 new outreach sites were served in FY 2002.
    - Thirty percent (30%) of private non-profit and for-profit agencies represented in the CHALENG Participant Survey were identified as faith-based organizations.

- VA/Community partnerships resulted in additional services outcomes in FY 2002.

    - 7,215 new beds (emergency, transitional, and permanent combined) were established.
    - 2,061 new treatment program slots were developed.

- Local VA/Community partnership efforts secured over $95 million in new grant monies for FY 2002, a 47% increase from the amount for FY 2001. U.S. Department of Housing and Urban Development (HUD) funding represented about two-thirds (66%) of FY 2002 grant monies.

- Increases in dental, child care and eye care service were secured in FY 2002.

    - 671 new patients received dental care.
    - 148 new child care slots were accessed.
    - 1,220 new patients received eye exams.

- CHALENG POCs worked on joint action plans to meet the needs of homeless veterans.

    - Seventy-eight percent (78%) of CHALENG POCs who selected job training and job placement as needs to work on in FY 2002 achieved some level of success.
    - New CHALENG POC action plans for FY 2003 addressed priority needs such as emergency, transitional and permanent housing, dental care, transportation, job training and placement, eye care, substance abuse treatment, detoxification, and dual diagnosis treatment.

Introduction

In 1993, the Department of Veterans Affairs (VA) launched Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans, a program designed to enhance the continuum of care for homeless veterans provided by the local VA and its surrounding community service agencies. The guiding principle behind Project CHALENG is that no single agency can provide the full spectrum of services required to help homeless veterans reach their potential as productive, self-sufficient citizens. Project CHALENG fosters coordinated services by bringing VA together with community agencies and other federal, state, and local government programs to raise awareness of homeless veterans' needs and to plan to meet those needs. This helps to improve homeless veterans' access to all types of services and eliminate duplication of efforts.

The legislation guiding this initiative is contained in Public Laws 102-405, 103-446 and 105-114. The specific legislative requirements relating to Project CHALENG are that local VA medical center and regional office directors:

- assess the needs of homeless veterans living in the area
- make the assessment in coordination with representatives from state and local governments, appropriate federal departments and agencies and non-governmental community organizations that serve the homeless population
- identify the needs of homeless veterans with a focus on health care, education and training, employment, shelter, counseling, and outreach
- assess the extent to which homeless veterans' needs are being met
- develop a list of all homeless services in the local area
- encourage the development of coordinated services
- take action to meet the needs of homeless veterans
- inform homeless veterans of non-VA resources that are available in the community to meet their needs

At the local level, VA medical centers and regional offices designate CHALENG Points of Contact (POCs) who are responsible for the above requirements. These CHALENG POCs – usually local VA homeless program coordinators – work with local agencies throughout the year to coordinate services for homeless veterans. (Note: for the remainder of this report, CHALENG Points of Contact will be referred to as "POCs.")

Update on CHALENG Activities

Several CHALENG initiatives have been undertaken/continued since the CHALENG FY 2001 report:

1. CHALENG and VA homeless veterans program staff participate at events across U.S.

Dr. Craig Burnette, the national coordinator for Project CHALENG, and Mr. Peter Dougherty, Director of Homeless Programs for the VA have been involved in numerous CHALENG meetings nationwide. Additionally they have presented on the CHALENG program at national conferences attended by staff from federal, state, and local

agencies. These conferences have highlighted the unique needs of homeless veterans and how VA and community partnerships are used to meet these needs.

2. CHALENG addresses chronic homelessness.

With the emphasis in the current administration on addressing the needs of the chronically homeless, the CHALENG process is an excellent opportunity for communities to look at chronic homelessness in regards to homeless veterans. VA NEPEC data (2002) shows that of the 45,000 homeless veterans seen by VA Healthcare for Homeless Veterans staff in FY 2002, 28% would have met one of the criteria for the current federal definition of a chronic homeless individual: i.e., continually homeless for longer than one year. Using CHALENG meetings, the VA and its local community partners have a way of assessing the needs of those who are chronically homeless and devising ways of intervening to break the cycle of homelessness.

3. CHALENG sees role in new HUD census requirement.

Starting in 2004, the Department of Housing and Urban Development (HUD) will require each local HUD Continuum of Care planning group to conduct a census of the homeless population in their Continuum every two years. At present, CHALENG POCs are asked to estimate the number of homeless veterans in their area through whatever methods they can use. The CHALENG meetings can be used as a catalyst for Continuums to start deciding the methods and means of conducting a census of the homeless in order to satisfy HUD requirements. This could also be used to count the number of veterans who are chronically homeless in the local community.

4. VA initiatives for high unmet needs presented at VA Health Care to Homeless Veterans and Social Work Service Conference, September 23-27, 2002, Potomac, MD.

During September 23 and 24, 2002 plenary sessions of the VA National Homeless Conference, speakers addressed CHALENG POCs from all over the U.S. on local and national initiatives addressing child care, long-term housing, dental services, and relationships with faith-based community agencies. VA Perry Point and VA Miami staff presented on partnering with community agencies to develop child care resources. VA Central Office staff reviewed strategies that POCs could employ with the Habitat for Humanity Program to develop permanent housing projects for homeless veterans. Experience with the current homeless dental initiatives and upcoming VHA dental policy and legislation was presented to POCs to stimulate planning for provision of dental services. Finally, BETAH Associates, a health communications firm, presented to POCs on resources that community faith-based programs could provide to homeless veterans.

5. The CHALENG report is available on the Internet.

In order to increase the accessibility of the CHALENG report and data, the Eight Annual Progress Report on Public Law 105-114 (including data tables and POC listing) was placed on a page of the VA Homeless Program. The website address is: http://www.va.gov/homeless/page.cfm?pg=17. As in 2002, CHALENG participants who listed their e-mail addresses will receive notification when the current report is posted on the website.

The CHALENG website has also served as a point of inquiry for homeless veterans and concerned families and friends. The national coordinator for Project CHALENG, whose e-mail address is on the CHALENG website, has responded to frequent inquiries regarding local services and resources for homeless veterans.

6. CHALENG data is utilized for CARF accreditation purposes.

Some VA Health Care for Homeless Veterans (HCHV) programs are mandated to become accredited by CARF, an accreditation agency for psychosocial rehabilitation programs. Most of these HCHV programs are being reviewed under the "Employment and Community Services" CARF standards. Section 2, "Standards for Achieving Quality Outcomes," sets standards regarding assessment of information from internal and external stakeholders. Much information from stakeholders is available in the annual CHALENG report including perceptions of needs of homeless veterans, ratings of levels of collaboration with the VA, and satisfaction with VA service accessibility. HCHV programs have been encouraged to use data from the CHALENG survey for CARF purposes. (Individual site reports of these data are included in the Appendix 1, 2 and 4-7.)

7. Participation in CHALENG by community agencies seeking VA Grant and Per Diem funding is being encouraged.

The VA Grant and Per Diem grant application process encourages community applicant agencies to demonstrate their involvement in the CHALENG assessment process. Further, as part of their application, community agencies must document the local needs of homeless veterans in their area: data from the annual CHALENG report can be used for this purpose.

Results from the Annual Survey

This *Ninth Annual Progress Report on Public Law 105-114* (Project CHALENG) is based on data collected from two surveys:

1. The CHALENG Point of Contact (POC) Survey. This survey, distributed to POCs only, is a self-administered questionnaire requesting information on the needs of homeless veterans in the local service area, development of new partnerships with local agencies, and progress in creating/securing new housing, treatment, and funding resources for homeless veterans.

2. The CHALENG Participant Survey. This survey is distributed by each POC at his/her local CHALENG meeting to various federal, state, county, city, non-profit and for-profit agencies that serve the homeless in the POC's local service area, as well as to local VA homeless program staff and to homeless and formerly homeless veterans. The self-administered survey requests information on the needs of homeless veterans in the local service area and perceptions of the level of success in VA and community efforts to coordinate and improve services for homeless veterans.

The FY 2002 Point of Contact and Participant Survey questionnaires were adapted from the FY 2001 versions.

In 2002, Veterans Integrated Service Networks (VISNs) 13 and 14 were re-organized into VISN 23. This report reflects that change in the POC listing (Appendix 8) and data tables.

CHALENG Survey Respondents

CHALENG Point of Contact Survey Respondents

Point of Contact survey questionnaires were mailed to all designated CHALENG POCs. Out of 139 surveys, 133 (96%) were returned. Six surveys were not returned, mainly due to staffing changeovers.

CHALENG Participant Survey Respondents

There were 3,451 respondents for the 2002 Participant Survey, a slight increase from the 3,343 respondents in 2001. Of the 3,451 respondents, 490 were VA staff and 2,321 were local government/community agency participants (hereafter referred to as "community participants"), and 640 respondents indicated no agency affiliation (many of these respondents were homeless veterans). Not including the 640 respondents who indicated no affiliation, 17% of the respondents were VA participants versus 83% who were community participants. Community participants represented 2,003 agencies from across the country.

Four hundred and eighty-eight (488) Participant Survey respondents identified themselves as homeless veterans (14% of all participants) and 231 identified themselves as formerly homeless veteran (7% of the total sample). Collectively, homeless and formerly homeless veterans represented 21% of all respondents in the FY 2002 Participant Survey. This is an increase from FY 2001 when homeless and formerly homeless veterans represented 9% of all Participant Survey respondents (314 individuals).

Respondents from agencies were asked to designate their organizational titles in the survey (see Table 1). As in prior years, survey respondents represented a range of

service functions from top-level executives and policymakers, to line-level service providers and their supervisors, to veteran service organization representatives.

Table 1. CHALENG Participant Survey Respondents' Organizational Function.

	FY 2002 (n=2,721)
Local service agency top managers (executive directors, chief executive officers)	18%
Mid-level managers, supervisors and advocates (program coordinators, veteran service officers)	34%
Clinicians and outreach workers (social workers, case managers, nurses)	33%
Elected government officials or their representatives	1%
Board Members	2%
Other (financial officers, attorneys, office staff, planning staff, etc.)	12%

VA representation in the Participant Survey was mainly through VA Medical Centers.

Table 2. VA Agency Staff Respondents.

VA Agency	FY 2002 (n=490)
VA Medical Center/Healthcare System staff	73%
VA Regional Office staff	5%
Vet Center staff	16%
VA Outpatient Clinic staff	4%
VA Other (Central Office and VISN staff)	2%

Participants were asked how long they had been personally involved in CHALENG, and how long their agencies had been involved in CHALENG.

Table 3. Years Involved by Participant and Agency in CHALENG.

Involved in CHALENG…	Personal Involvement (n=1,981)	Agency Involvement (n=1,463)
Since first local CHALENG meeting (eight year ago or more)	10%	26%
Two to seven years ago	29%	37%
One year ago	13%	10%
First time today	48%	27%

Nearly two-thirds (63%) of the participants' agencies had been involved with CHALENG for at least two years or since CHALENG's inception. This suggests the development and maintenance of long-time agency relationships between the VA and outside community groups.

Needs of Homeless Veterans

Rankings of Needs by VA and Community Participants

As in past years, Participant Survey respondents were asked to rate how well 36 pre-identified homeless veteran service needs were met in their community, using a five-point scale ranging from "Not Met" (1) to "Met" (5). Table 4 shows the results for the entire sample of respondents for 2002 (n=3,451), as well as the previous two years.

(Note: needs scores for each VA facility are listed in Appendix 1 [VA respondents] and 2 [community respondents], and needs scores for each of the 21 VISNs [VA and community respondents combined] are listed in Appendix 3.)

Table 4. Met and Unmet Needs of Homeless Veterans (Combined VA Staff and Community Participants' Assessment: 2002, 2001, 2000 CHALENG Survey).

	Need of homeless veterans	Average Score 2002 (n=3,451)	Average Score 2001 (n=3,343)	Average Score 2000 (n=3,331)	Need is met = score of 5
1	**TB testing**	3.98	3.55	3.39	
2	**Hepatitis C testing**	3.92	3.37	N/A	
3	**TB treatment**	3.89	3.40	3.25	
4	**Medical services**	3.84	3.53	3.46	
5	**Food**	3.77	3.68	3.60	
6	**Emotional/psychiatric services**	3.74	3.19	3.05	
7	**Substance abuse treatment**	3.73	3.28	3.13	
8	**AIDS/HIV testing/counseling**	3.72	3.38	3.25	
9	**Help with medication**	3.64	3.22	3.06	
10	**VA disability/pension**	3.61	3.27	3.23	
11	Clothing	3.59	3.46	3.44	
12	Women's health care	3.54	3.14	3.02	
13	Treatment for dual diagnosis	3.50	3.00	2.85	
14	Detoxification from substances	3.48	3.09	2.93	
15	Spiritual	3.44	3.23	3.13	
16	Help getting needed documents or identification	3.40	3.17	3.09	
17	Assistance with personal hygiene (shower, haircut, etc.)	3.39	3.18	3.06	
18	Emergency (Immediate) shelter	3.38	3.17	3.12	
19	Help with finding a job or getting employment	3.32	3.09	3.02	
20	Discharge upgrade	3.19	2.87	2.86	
21	Job training	3.17	2.92	2.88	
22	SSI/SSD process	3.08	2.95	2.96	
23	Welfare payments	3.08	2.93	2.94	
24	Halfway house or transitional living facility	3.01	2.80	2.56	
25	Drop-in center or day program	3.00	2.79	2.73	
26	Family counseling	2.96	2.84	2.82	
27	**Guardianship (financial)**	2.96	2.66	2.63	
28	**Education**	2.92	2.87	2.76	
29	**Help with transportation**	2.91	2.82	2.78	
30	**Help managing money**	2.88	2.66	2.57	
31	**Glasses**	2.65	2.64	2.52	
32	**Eye care**	2.60	2.64	2.48	
33	**Legal assistance**	2.51	2.56	2.52	
34	**Long-term, permanent housing**	2.40	2.33	2.17	
35	**Dental care**	2.25	2.38	2.31	
36	**Child care**	2.18	2.27	2.23	
					Need is unmet = score of 1

For FY 2002, Table 4 indicates that child care, dental care, long-term, permanent housing, legal assistance, eye care, glasses, help managing money, transportation, education and financial guardianship were the ten highest unmet needs for homeless veterans as determined by VA staff and community participants combined.

Child care topped the list of unmet needs and has been the highest unmet need for several years. In last year's CHALENG report, POCs said child care is especially needed when a veteran enters a residential treatment program, is actively seeking a job, or when a veteran and his/her family are seeking shelter together. In FY 2002, seven POCs (6% of all participating POCs) reported adding a total of 148 new child care slots for use in their homeless veterans programs. (See the FY 2001 CHALENG report for a discussion in greater depth of the issues surrounding child care.)

Legal assistance, money management assistance, and financial guardianship represent a cluster of ancillary needs that are important to keep homeless veterans out of legal difficulties and become less financially vulnerable. Education is also an important asset that can lead to a better job and increased self-sufficiency.

The need for long-term, permanent housing remains high. This is not surprising, given that developing these types of housing is expensive and complicated. As indicated later in this report, permanent housing remains the #1 need that both VA POCs and community agency partners would like to address in FY 2003.

Dental care was the second highest unmet need identified for homeless veterans this year. As difficult as it has been for local VAMCs to address the problem of providing dental services to non-service connected homeless veterans, a hopeful initiative has been launched during FY 2003. Public Law 107-95 (The Homeless Veterans Comprehensive Assistance Act of 2001) called for a one-time course of dental care for veterans enrolled in specific VA homeless programs. In December 2002, the Veterans Health Administration issued VHA Directive 2002-080 that outlined the guidelines for this care. The directive calls for providing dental service and treatment which is "medically necessary" for veterans to gain/regain employment and/or to alleviate pain or treat disease. Directive 2002-080 will be gradually implemented in FY 2003. For FY 2002, 14 POCs (19% of all participating POCs) reported adding new/expanded dental services with 671 new patients receiving dental care.

Unlike dental care, there were no special initiatives for eye care for homeless veterans. Eye care remains a scare resource in the VA and a high unmet need. Eleven percent (11%) of POCs reported adding new eye care resources in FY 2002 with 1,220 new patients served.

Turning to *highest met* needs as rated by the combined VA/community sample, many of the top ten categories were health services-related: TB testing, TB treatment, Hepatitis C testing, medical services, help with medication, HIV/AIDS testing/counseling, substance abuse treatment, and emotional psychiatric services. Most of these services (along with assistance in securing VA disability/pension) are commonly offered by VA

Medical Centers. Food is a basic need addressed at virtually all homeless shelters and programs.

A Multi-year Overview of Needs

There is substantial agreement between VA and community participants when their ratings are looked at separately (Tables 5-8). Nine items appear on both VA and community participants' top-ten met need list and seven items appear on both VA and community unmet need lists. This seems to indicate that VA and non-VA providers share a similar perspective on what needs are being met and not met for the homeless veteran populations they jointly serve.

As with last year's five-year review of needs, the consistency with which participants rate needs as unmet or met from 1998 through 2002 is remarkable (see Tables 5 through 8). While the order of needs changes slightly from year to year, the perception of whether needs are met or unmet does not. The top unmet needs that emerge in both VA and community participant assessments across all five years are child care, dental care, eye care/glasses, long-term, permanent housing, legal assistance, and help managing money. The top met needs that appear across all five years are food, medical services, HIV/AIDS testing and counseling, TB testing, and TB treatment.

Five-Year Comparison - VA/Community Assessment of Homeless Veteran UNMET Needs

Table 5. Top Ten Highest *Unmet* Needs Identified by VA Staff.

1998	1999	2000	2001	2002
1. Dental care	1. Child care	1. Child care	1. Child care	1. Child care
2. Child care	2. Long-term, permanent housing	2. Dental care	2. Dental care	2. Dental care
3. Long-term, permanent housing	3. Legal assistance	3. Long-term, permanent housing	3. Long-term, permanent housing	3. Long-term, permanent housing
4. Eye care	4. Dental care	4. Legal assistance	4. Legal assistance	4. Legal Assistance
5. Glasses	5. Eye care	5. Eye care	5. Glasses	5. Eye care
6. Legal assistance	6. Glasses	6. Glasses	6. Eye care	6. Glasses
7. Transportation	7. Halfway house/ transitional living	7. Help managing money	7. Help managing money	7. Help managing money
8. Help managing money	8. Help managing money	8. Halfway house/ transitional living	8. Guardianship (financial)	8. Transportation
9. Halfway house/ transitional living	9. Transportation	9. Transportation	9. Transportation	9. Education
10. Guardianship (financial)	10. Education	10. Education	10. Family Counseling	10. Family Counseling

Table 6. Top Ten Highest *Unmet* Needs Identified by Community Participants.

1998	1999	2000	2001	2002
1. Long-term, permanent housing	1. Long-term, permanent housing	1. Long-term, permanent housing	1. Long-term, permanent housing	1. Long-term, permanent housing
2. Child care	2. Child care	2. Child care	2. Child care	2. Child care
3. Dental care	3. Dental care	3. Dental care	3. Dental care	3. Dental care
4. Eye care	4. Halfway house/ transitional living	4. Eye care	4. Legal assistance	4. Help managing money
5. Glasses	5. Eye care	5. Glasses	5. Help managing money	5. Legal assistance
6. Transportation	6. A. Glasses B. Legal assistance (tie)	6. Halfway house/ transitional living	6. Eye care	6. Eye care
7. Help managing money	7. Guardianship (financial)	7. Help managing money	7. Glasses	7. Glasses
8. Halfway house/ transitional living	8. Drop in/day program	8. Legal assistance	8. Guardianship (financial)	8. Guardianship (financial)
9. Legal assistance	9. Transportation	9. Guardianship (financial)	9. Halfway house/ transitional living	9. Halfway house/ transitional
10. Guardianship (financial)	10. Help managing money	10. Drop in/day program	10. Drop in/day program	10. Drop in/day program

Five-Year Comparison - VA/Community
Assessment of Homeless Veteran MET Needs

Table 7. Top Ten Highest *Met* Needs Identified by VA Staff.

1998	1999	2000	2001	2002
1. Medical services	1. Medical services	1. Medical services	1. TB testing	1. TB testing
2. Food	2. TB testing	2. TB testing	2. Medical services	2. Hepatitis C testing
3. TB testing	3. Substance abuse treatment	3. Food	3. Hepatitis C testing	3. TB treatment
4. Substance abuse treatment	4. Emotional or psychiatric services	4. VA disability/ pension	4. TB treatment	4. Medical Services
5. HIV/AIDS testing/ counseling	5. TB treatment	5. Clothing	5. Substance abuse treatment	5. Food
6. Emotional or psychiatric services	6. A. Food B. HIV/AIDS testing/ counseling (tie)	6. TB Treatment	6. Food	6. Emotional or psychiatric services
7. TB treatment	7. VA disability/ pension	7. HIV/AIDS testing	7. HIV/AIDS testing	7. Substance abuse treatment
8. VA disability/ pension	8. Women's health care	8. Substance abuse treatment	8. Emotional or psychiatric services	8. HIV/AIDS testing
9. Women's health care	9. Help with medication	9. Emotional or psychiatric services	9. Help with medication	9. Help with medication
10. Clothing	10. Clothing	10. Help with medication	10. Clothing	10. VA disability/ pension

Table 8. Top Ten Highest *Met* Needs Identified by Community Participants.

1998	1999	2000	2001	2002
1. Food	1. Food	1. Food	1. Food	1. Food
2. TB testing	2. Clothing	2. Clothing	2. Clothing	2. TB testing
3. Medical services	3. TB testing	3. Medical services	3. Medical services	3. Medical services
4. Clothing	4. Medical services	4. TB testing	4. TB testing	4. Clothing
5. HIV/AIDS testing/ counseling	5. A. TB treatment B. HIV/AIDS testing/ counseling (tie)	5. HIV/AIDS testing	5. TB treatment	5. TB treatment
6. TB treatment	6. Spiritual	6. TB treatment	6. HIV/AIDS testing	6. Hepatitis C testing
7. VA disability/ pension	7. VA disability/ pension	7. VA disability/ pension	7. Hepatitis C testing	7. HIV/AIDS testing
8. Spiritual	8. Documents/ID	8. Immediate/ emergency shelter	8. VA disability/ pension	8. VA disability/ pension
9. Substance abuse treatment	9. Substance abuse treatment	9. Spiritual	9. Spiritual	9. Substance abuse treatment
10. Welfare payments	10. Personal hygiene	10. Personal hygiene	10. Substance abuse treatment	10. Help with medication

Veterans' Perception of Needs

Homeless veterans' perception of their own needs as compared to VA and community participant perception of their needs was also examined. In FY 2002, homeless and formerly homeless veteran participants (n=719) were present in 85 sites. Table 9 reports the systemwide homeless veterans responses compared with the combined VA staff and community participant responses (excluding VA staff and community participants who identify as formerly homeless veteran).

Table 9. Top Ten Highest Unmet and Met Needs Identified by Homeless Veterans versus VA Staff and Community Participants, FY 2002.*

10 Highest Unmet Needs		10 Highest Met Needs	
Homeless Veterans (n=719)	**Combined VA and Community Participants (n=2,359)**	**Homeless Veterans (n=719)**	**Combined VA and Community Participants (n=2,359)**
1. Child care	1. Long-term, permanent housing	1. TB testing	1. Food
2. Legal assistance	2. Child care	2. TB treatment	2. TB testing
3. Long-term, permanent housing	3. Dental care	3. Hepatitis C testing	3. Medical services
4. Dental Care	4. Legal assistance	4. Substance Abuse Treatment	4. Clothing
5. Guardianship (financial)	5. Eye care	5. Help with medication	5. TB treatment
6. Welfare payments	6. Glasses	6. Medical services	6. Hepatitis C testing
7. SSI/SSD	7. Help managing money	7. Food	7. HIV/AIDS testing/ counseling
8. Help managing money	8. Guardianship (financial)	8. HIV/AIDS testing/counseling	8. VA disability/ pension
9. Discharge upgrade	9. Halfway house or transitional living facility	9. Detoxification	9. Substance abuse treatment
10. Family counseling	10. Drop-in center or day program	10. Emotional or psychiatric services	10. Help with medication

*373 cases which did not indicate whether they were/were not homeless or formerly homeless veterans were excluded from this analysis.

As with last year, there were some important differences between homeless/formerly homeless veterans identification of highest unmet needs compared to VA and community participants. Unlike VA/community participants, homeless/formerly homeless veterans placed welfare payments, SSI/SSD, and discharge upgrade in the top ten list of highest unmet needs. Thematically, this suggests the personal desire of homeless/formerly homeless veterans to secure access to health and financial benefits in transitioning off the streets.

Unlike VA/community participants, homeless veterans identified family counseling as one of their top ten unmet needs. Family relationships are important in the phenomenon of homelessness. Poor relationships can promote drug use, exacerbate mental disorders, and cause financial drain and isolation. Good relationships can foster the homeless veteran's reintegration into society as a member of a mutually supportive family.

A record number of sites had homeless/formerly homeless veterans respondents for the participant survey: 85 sites (62% of all reporting sites) compared to 63 sites (45% of all reporting sites in 2001) last year. We continue to encourage POCs to involve homeless veterans in the CHALENG process.

Site Estimates of Numbers of Homeless Veterans and Housing Capacity

Homeless Veteran Estimate and Sources

In an effort to gauge the extent of homeless veterans needing services, each POC was asked to estimate the number of homeless veterans in her/his service area. The estimated number of homeless veterans across sites reported by the POCs for the FY 2002 Report is 299,321. Individual site estimates are presented in Appendix 6. The FY 2001 CHALENG Report describes the complexities and limitations of estimating the number of homeless veterans in the U.S.

The FY 2002 estimate of homeless veterans may represent an increase as it is slightly higher than estimates listed in the FY 2000 (292,105) and FY 2001 (294,840) CHALENG Reports.

For the homeless veterans estimates by POCs, the following sources were reported: local HUD Continuum of Care reports (28%), U.S. Census data (14%), VA low-income population estimates (14%), local homeless census studies (state, county, local university, etc.) (54%), VA client data (28%), estimates from local homeless community coalition/providers (72%) and VA staff impressions (49%). About three-quarters of the POCs (74%) used more than one source.

Bed Availability and Need

To aid in determining the need for housing for homeless veterans, POCs were asked to include an estimate of the number of beds available for homeless veterans in their local area for three types: 1) emergency, 2) transitional, and 3) permanent. POCs were also asked to estimate the number of veterans turned away in each of these bed categories (except for transitional housing) because of unavailability, and the number of beds needed beyond the present or anticipated capacity to meet the local needs of homeless veterans.

As a data quality check, information on bed capacity, turnaways, and bed need from this year's CHALENG POC survey were compared to FY 2001 data. Large increases/decreases at sites between years were identified and follow-up phone calls were made to POCs to verify these changes. Approximately 33% of all participating POCs were contacted. In some cases, the changes (such as drops in capacity due to program closures) were substantiated. For some sites, dramatic differences reflected what POCs believed were more accurate re-estimates for FY 2002. In a few cases, POCs re-submitted corrected estimates.

Tables 10 and 11 display bed availability and need estimates for both FY 2001 and FY 2002.

Table 10. Bed Capacity and Need Assessment (FY 2001).

Type of bed	Presently available (est.) FY 2001	Veterans turned away (est.) FY 2001	Needed beyond present capacity (est.) FY 2001
Emergency	63,420	17,361	13,119
Transitional	29,007	-	14,064
Permanent	19,714	15,019	19,436

Table 11. Bed Capacity and Need Assessment (FY 2002).

Type of bed	Presently available (est.) FY 2002	Veterans turned away (est.) FY 2002	Needed beyond present capacity (est.) FY 2002
Emergency	62,125	14,739	14,406
Transitional	27,407	-	13,523
Permanent	23,121	9,396	19,934

Comparing the data from FY 2001 and FY 2002, there was an increase in the need for emergency housing. This may be consistent with the U.S. Conference of Mayor's Report (2002) that documented an average 19% increase in requests for emergency shelter and emergency food assistance in 25 survey cities across the U.S.

Both estimated transitional housing capacity and estimated transitional housing need decreased between FY 2001 and 2002.

Between FY 2001 and 2002, the need for permanent housing remained stable as existing capacity increased.

Assessment of VA and Community Partnering

As stated in the Introduction, the CHALENG mandate is to bring VA and community service providers together in a partnership to encourage the development of coordinated services for homeless veterans. For this year's report, we examined three indicators of VA and community partnership. These are: (1) partnership integration and implementation measures, (2) VA involvement in community homeless coalitions, and (3) interagency agreements.

Partnership Integration and Implementation Measures

Since FY 2000, CHALENG has used two sets of questions to ascertain the level of VA/community partnering as perceived by community (non-VA) participants: (A) *Integration* measures and (B) *Implementation* measures. The integration questions were adapted from nationwide ACCESS (Access to Community Care and Effective

Services and Supports) study of service system integration for homeless clients with severe mental illness (Randolph et al., 1997).

Integration measures consisted of eight questions asking community participants from the Participant Survey to rate the following:

1. *VA Accessibility*: accessibility of VA services to homeless veterans.
2. *Community Accessibility:* accessibility of community services to homeless veterans.
3. *VA Commitment:* willingness of VA to cooperate with the community participant's agency to serve homeless veterans.
4. *Community Commitment:* willingness of the community participant's agency to cooperate with VA to serve homeless veterans.
5. *VA Cooperation:* VA's level of cooperation with the community participant's agency in coordinating services for homeless veterans.
6. *Community Cooperation:* The community participant's agency level of cooperation with VA in coordinating services for homeless veterans.
7. *VA Coordination:* the ability of VA to coordinate clinical services for homeless veterans with the community participant's agency.
8. *Community Coordination:* the ability of the community participant's agency to coordinate clinical services for homeless veterans with VA.

Thus, community participants were asked to separately rate the performance of (A) the local VA and (B) the community participant's agency. A five-point scale was used for each item (1=not accessible, not committed etc. to 5=highly accessible, highly committed, etc.).

Implementation measures consisted of 12 items pertaining to concrete activities associated with VA and community partnering. Community participants were asked to rate the level of implementation of the following strategies between their agency and VA:

1. *Regular Meetings:* Formal, regular meetings of VA and the community participant's agency to exchange information and plan.
2. *Service Co-location:* Provision of services by VA and the community participant's agency in one location.
3. *Cross-training*: Training of VA and the community participant agency's staff to each others' objectives, procedures, and services.
4. *Interagency Agreements*: Agreements between VA and the community participant's agency regarding collaboration, referrals, client information sharing, and/or coordinating services.
5. *Client Tracking:* Computer tracking system enabling VA and the community participant's agency to share client information.
6. *Joint Funding:* Combined/layering funding between VA and the community participant's agency to create new resources or services.
7. *Standard Forms:* Standardized forms that clients fill out once to apply for services at the VA and the community participant's agency.

8. *Joint Service Teams:* Service teams comprised of staff from both VA and the community participant's agency to assist clients with multiple needs.
9. *Combined Programs:* Combined programs from VA and the community participant's agency under one administrative structure.
10. *Flexible Funding:* Flexible funding to promote service integration between the VA and the community participant's agency: for example, funds to pay for emergency services not usually available to clients.
11. *Special Waivers:* Waiving requirements for funding, eligibility, or service delivery to reduce service barriers, promote access, and/or avoid service duplication.
12. *System Coordinator:* Creation of a specific staff position focusing on improving system integration between the VA and the community participant's agency.

All implementation items used the same four-point scale: 1=none (no steps taken to initiate implementation of the strategy), 2=low (in planning and/or initial minor steps taken), 3=moderate (significant steps taken but full implementation not achieved), and 4=high (strategy full implemented).

Table 12 shows the results of the integration ratings by community participants (mean scores of aggregated sites). We compared the aggregated integration scores of FY 2001 versus FY 2002. Using paired t-tests, we found that site increases in community cooperation scores between FY 2001 and FY 2002 were statistically significant (<.05) — a possible indicator of improvement in the willingness of community agencies to work with VA in serving homeless veterans. None of the other increases in integration scores were statistically significant.

Table 12. Community Agency Participants' Ratings of Partnership Integration in CHALENG Participant Survey (Aggregated by Site).

Integration Items	Community Respondents FY 2001 (123 sites)	Community Respondents FY 2002(123 sites)
VA Accessibility (1=not accessible...5=highly accessible)	3.58	3.59
Community Accessibility (1=not accessible...5=highly accessible)	3.40	3.41
VA Commitment (1=not committed...5=highly committed)	3.82	3.86
Community Agency Commitment (1=not committed...5=highly committed)	3.99	4.03
VA Cooperation (1=not cooperative...5=highly cooperative)	3.78	3.83
Community Agency Cooperation (1=not cooperative...5=highly cooperative)	3.81	3.89*
VA Service Coordination (1=not able to coordinate...5=highly able)	3.51	3.59
Community Agency Service Coordination (1=not able to coordinate...5=highly able)	3.47	3.55

*Indicates item that was statistically significant (<.05) when FY 2001 and FY 2002 mean scores aggregated by POC site were compared using a paired t-test.

Implementation scores for FY 2001 and FY 2002 were also reviewed. Again, data were aggregated by site and paired t-tests were conducted. There were statistically significant increases in development of interagency agreements, shared client tracking

systems, and special waivers. Collectively, these three items may represent initial concrete steps in coordinating/collaborating services between the VA and community agencies.

Table 13. Community Agency Participants' Ratings of Partnership Implementation in the CHALENG Participant Survey (Aggregated By Site).

Implementation Items[a]	Community Respondents FY 2001 (123 sites)	Community Respondents FY 2002 (123 sites)
Regular Meetings	2.58	2.60
Service Co-location	2.09	2.08
Cross-training	1.97	2.06
Interagency Agreements	2.41	2.55*
Client Tracking	1.54	1.63*
Joint Funding	1.61	1.61
Standard Forms	1.60	1.68
Joint Service Teams	2.12	2.17
Combined Programs	1.55	1.62
Flexible Funding	1.59	1.62
Special Waivers	1.58	1.66*
System Coordinator	1.66	1.73

[a] 1=none, 2=low, 3=moderate, 4=high

*Indicates items that were statistically significant (<.05) when FY 2001 and FY 2002 mean scores aggregated by POC site were compared using a paired t-test.

Taken together, the integration and implementation scores suggest some improvement in promoting greater service collaboration with VA and community providers moving towards more seamless delivery of care through strategies like creating interagency agreements, developing shared client tracking systems, and creating special waivers. (For implementation and integration scores by site, please see Appendices 4 and 5).

VA Involvement in Local Homeless Coalitions

Involvement in local homeless coalitions has been identified as a useful way for VA staff to network with local homeless service providers and develop partnerships. Ninety-one percent (91%) of the POC Surveys indicated there was a local homeless coalition. VA staff attended the local coalition at all but two POC sites, participating in 81% of the available meetings (1456 of a possible 1782 meetings).

Interagency Agreements

Existing Interagency Agreements: CHALENG POCs reported on VA efforts to serve homeless veterans through arrangements with local community agencies. For the first time, CHALENG POCs were asked to identify whether they *currently* had interagency agreements with: correctional facilities, psychiatric/substance abuse inpatient programs, nursing homes, and faith-based organizations. Table 14 shows the nature of current interagency agreements.

Table 14. Percentage of POCs (n=133) Indicating Interagency Agreements with Select Program Types.

	Any	Formal	Informal
Correctional Facilities (jails, prisons, courts)	46%	4%	44%
Psychiatric/substance abuse inpatient (hospitals, wards)	61%	20%	43%
Nursing homes	36%	22%	15%
Faith-based organizations	72%	19%	57%

Almost three-quarters (72%) of POC respondents indicated their VA had some kind of interagency agreement with a faith-based organization. This is not surprising, given the fact that many faith-based organizations have a long history in serving the poor and homeless. A majority of POCs (61%) indicated ties with psychiatric/substance abuse inpatient programs – a reminder of the link between mental illness and homelessness and the need to coordinate services between mental health and homeless agencies.

Forty-six percent (46%) of POCs had relationships with local correctional facilities. Many incarcerated veterans are at high-risk for homelessness upon leaving jail or prison. Several VA homeless programs conduct outreach in local jails and prisons to help veterans arrange transitional housing and substance abuse/mental health treatment after their scheduled release.

Over a third (36%) of POCs had arrangements with nursing homes. This may reflect the aging of the homeless population and the need for facilities to address the multiple medical needs of older and/or chronically ill veterans.

New Interagency Agreement and Outreach Efforts: VA staff continued to make sharing agreements and to identify and serve new outreach sites. Table 15 displays numbers for new interagency sharing agreements (formal and informal arrangements) and outreach sites, broken down by VISN. Table 16 displays interagency agreements by service type.

Table 15. Networking Outcomes Through the CHALENG Process by VISN for FY 2002.

VISN	Informal agreements	Informal agreements	Agreements (total)	Number of New Homeless Outreach Sites
1	4	18	22	33
2	2	4	6	13
3	13	15	28	31
4	4	12	16	14
5	4	14	18	9
6	2	17	19	16
7	10	23	33	12
8	2	6	8	21
9	0	2	2	3
10	4	3	7	12
11	6	16	22	20
12	2	5	7	34
15	0	4	4	3
16	2	19	21	20
17	2	5	7	7
18	5	10	15	52
19	0	11	11	10
20	6	12	18	32
21	0	10	10	17
22	4	2	6	27
23	4	28	32	17
Totals, All VISNs (FY 2002):	**76**	**236**	**312**	**403**
Totals, All VISNs (FY 2001):	**145**	**243**	**388**	**642**

Table 16. Types of Agencies New Interagency Agreements Were Made With in FY 2002.

	Total (% of all new agreements)	**Formal**	**Informal**
Correctional Facilities (jails, prisons, courts)	45 (14%)	4	41
Psychiatric/substance abuse inpatient (hospitals, wards)	27 (9%)	12	15
Nursing homes	15 (5%)	7	8
Faith-based organizations	73 (23%)	18	55
Other Organizations	152 (49%)	35	117

In FY 2002, POCs were active in establishing new relationships with outside community agencies, though overall, the number of new interagency agreements and new outreach sites secured declined from FY 2001.

Nature of New Interagency Agreements: 86 out of 133 reporting POC sites (65%) had at least one new sharing agreement with a community agency. By far, the most frequent topic of the new sharing agreements was long-term, permanent housing – 71% of the POC sites who reported a new interagency agreement indicated that securing permanent housing for veterans was part of the sharing agreement. Given that formerly homeless/formerly homeless veterans ranked long-term, permanent housing as the third highest unmet need in the Participant survey, it is encouraging that permanent housing was one focus of so many new VA/community interagency agreements (see Table 17 for complete list).

Table 17. Subject of New Interagency Agreements between VA and Community Providers.

Need	Percentage of POCs With New Interagency Agreements in 2002 Who Indicated This Need was Addressed in the Agreement (n=86)*
Long-term, permanent housing	71%
Halfway house or transitional living facility	41%
Dental care	29%
Emergency (Immediate) shelter	27%
Help with finding a job or getting employment	14%
Detoxification from substances	9%
Job training	8%
Substance abuse treatment	7%
Treatment for dual diagnosis	7%
Drop-in center or day program	7%
Emotional/psychiatric services	6%
Legal assistance	6%
VA disability/pension	5%
Glasses	5%
Child care	5%
Eye care	4%
HIV/AIDS testing/counseling	2%
Food	1%
Clothing	1%
Help with transportation	1%
Help getting needed documents or identification	1%
Women's health care	1%
Welfare payments	1%
Guardianship (financial)	1%
Family counseling	1%
Assistance with personal hygiene (shower, haircut, etc.)	0%
Medical services	0%
Help with medication	0%
Help managing money	0%
Education	0%
SSI/SSD process	0%
Spiritual	0%
TB testing	0%
TB treatment	0%
Discharge upgrade	0%
Hepatitis C Testing	0%

*Multiple needs addressed in the new interagency agreements may be identified by POCs

Participation of Faith-Based Programs in CHALENG

On January 29, 2001, the President issued Executive Order 13198 which created Centers for Faith-Based and Community Initiatives in five cabinet departments (Health and Human Services, Housing and Urban Development, Education, Labor, and Justice). The Executive Order's mandate was to identify barriers that might prevent faith-based and other community organizations from providing social services in partnership with the Federal government. The initiative acknowledged the potential value of community faith-based organizations in serving the needs of disadvantaged groups.

In the spirit of Executive Order 13198, our report examined the current participation of faith-based organizations in the CHALENG process. Five questions were explored.

1. What percentage of CHALENG participants identified themselves as representing faith-based agencies?
2. How long had faith-based organizations been involved with CHALENG?
3. Did faith-based organizations perceive homeless veteran needs any differently from non faith-based organizations?
4. Were faith-based organization as engaged in community collaborations as non faith-based organizations?
5. Did faith-based organizations perceive their relationships with VA any differently than non faith-based organizations?

1, 2. Participation of faith-based organizations in CHALENG. For the FY 2002 CHALENG Participant Survey, 1263 respondents indicated they were from a total of 1095 private community non-profit and for-profit agencies. Of the 1263 respondents, 362 (29%) indicated they were from faith-based organizations and 901 (71%) were from non faith-based organizations. Based on these responses, it was determined that 328 (30%) of the 1095 private community non-profit and for-profit agencies represented at CHALENG in FY 2002 were faith-based organizations.

In terms of history with CHALENG, analysis revealed little differences. Forty-three percent (43%) of individuals from faith-based agencies had been involved with CHALENG for two years or more compared to 38% of individuals from non faith-based organizations. Also, 61% of faith-based agencies represented in the FY 2002 CHALENG surveys had been involved with CHALENG for at least two years, compared to 59% of non faith-based organizations.

3. Perception of level of homeless veteran need. Ratings of need for homeless veterans from the 36 pre-identified need categories were examined. A comparison was made between community respondents from faith-based agencies versus respondents from non faith-based agencies (see Table 18 below).

Table 18. Top Five Unmet and Met Needs Identified by Community Participants from Faith-based Agencies versus Non Faith-Based Agencies, FY 2002.

Five Highest Unmet Needs		**Five Highest Met Needs**	
Faith-Based Community Agency Respondents (n=362)	**Non Faith-Based Community Agency Respondents (n=901)**	**Faith-Based Community Agency Respondents (n=362)**	**Non Faith-Based Community Agency Respondents (n=901)**
1. Long-term, permanent housing 2. Child care 3. Dental care 4. Eye care 5. Guardianship (financial)	1. Long-term, permanent housing 2. Child care. 3. Dental Care 4. Help managing money 5. Glasses	1. Food 2. Clothing 3. TB Testing 4. Medical Services 5. TB treatment	1. Food 2. Medical Services 3. TB testing 4. Clothing 5. TB treatment

Table 18 indicates little difference in ratings between respondents from faith-based agencies versus non faith-based agencies. In terms of the top five unmet needs identified, respondents from faith-based and non faith-based agencies shared three

categories; the remaining unique categories were similar in theme (i.e., glasses versus eye care, help managing money versus financial guardianship). In terms of highest met needs, faith-based and non faith-based agency respondents shared agreement on all five categories.

4, 5. Faith-based agency engagement in/perceptions of collaboration with VA. To examine faith-based agency collaborations with VA in serving homeless veterans, Implementation and Integration measures were examined. As explained in the *Assessment of VA and Community Partnering* section, the Implementation measures consisted of 12 items pertaining to concrete activities associated with partnering between a community service agency and VA. The Integration measures consisted of eight items related to general perceptions on the level of collaboration between the local VA and the respondent's community service agency.

T-tests were conducted comparing the mean scores of identified faith-based respondents versus non faith-based respondents from community agencies. (see Tables 19a and 19b below).

Table 19a. Community Agency Participants' Ratings of Partnership Implementation in the CHALENG Participant Survey: Faith-based Agency Participants versus Non Faith-based Agency Participants.

Implementation Items[a]	Respondents from Faith-based Organizations (n=362)	Respondents from Non Faith-based Organizations FY 2002 (n=901)
Regular Meetings	2.69*	2.54
Service Co-location	2.21**	2.00
Cross-training	2.13*	1.98
Interagency Agreements	2.67	2.55
Client Tracking	1.66	1.58
Joint Funding	1.73*	1.58
Standard Forms	1.75*	1.60
Joint Service Teams	2.26	2.16
Combined Programs	1.66	1.53
Flexible Funding	1.64	1.58
Special Waivers	1.76*	1.61
System Coordinator	1.74	1.68

[a] 1=none, 2=low, 3=moderate, 4=high

*Indicates items that were statistically significant (<.05) when FY 2001 and FY 2002 mean scores are compared. **(<.01).

Table 19b. Community Agency Participants' Ratings of VA/Community Agency Integration in the CHALENG Participant Survey: Faith-based Agency Participants versus Non Faith-based Agency Participants.

Integration Items	Respondents from Faith-based Organizations (n=362)	Respondents from Non Faith-based Organizations FY 2002 (n=901)
VA Accessibility (1=not accessible...5=highly accessible)	3.74***	3.49
Community Accessibility (1=not accessible...5=highly accessible)	3.50*	3.35
VA Commitment (1=not committed...5=highly committed)	4.00**	3.77
Community Agency Commitment (1=not committed...5=highly committed)	4.19*	4.04
VA Cooperation (1=not cooperative...5=highly cooperative)	3.93*	3.78
Community Agency Cooperation (1=not cooperative...5=highly cooperative)	3.97	3.89
VA Service Coordination (1=not able to coordinate...5=highly able)	3.68	3.54
Community Agency Coordination (1=not able to coordinate...5=highly able)	3.67	3.60

*Indicates items that were statistically significant (<.05) when FY 2001 and FY 2002 mean scores are compared. **(<.01) ***(<.001)

Significant differences were found in six implementation activities. Faith-based agency respondents had higher mean scores in regular interagency coordinating meetings, service co-location, cross-training, pooled funding, standardized client forms, and use of special waivers.

Also, significant differences were found in five integration items. Compared to non faith-based agency respondents, faith-based agency respondents rated the local VA higher in its service accessibility to homeless veterans and its levels of commitment and cooperation in partnering with the respondent's agency in serving homeless veterans. Also, faith-based agency respondents rated local homeless veteran access to community services higher than non faith-based agency respondents. Finally, faith-based agency respondents also rated their agencies higher in their commitment to partnering with VA compared to non faith-based agency respondents.

Summary of Faith-Based Organization Findings: Close to one-third of (30%) of all private nonprofit and for-profit agencies represented in the CHALENG Participant Survey were identified as faith-based. Similar percentages of faith-based agencies and non faith-based agencies (and individuals from these agencies) had been involved with CHALENG for at least two years or more. Respondents from faith-based and non faith-based agencies are very similar in their ratings of highest unmet and highest met needs for homeless veterans. Collectively, these results suggest a large minority of CHALENG agencies identify as faith-based. These agencies have been involved just as long in the CHALENG process as non faith-based organizations and share similar perceptions of priorities in addressing needs of homeless veterans.

Further, respondents from faith-based agencies indicated higher levels of implementation of six activities associated with service collaboration between a community agency and VA: regular interagency meetings, service coordination, cross-training, shared funding, standardized client forms and use of waivers. Also, analysis of the integration items revealed that faith-based agency respondents rated the VA higher in its willingness to partner with community agencies compared to non faith-based agency respondents. These data represent differences in perception and may not reflect differences in actual performance.

Agencies that do identify as faith-based represent an important part of the CHALENG effort to serve homeless veterans. As noted in the previous section on interagency agreements, 72% of POC sites had an existing relationship with a faith-based agency, and 23% of all new agreements for FY 2002 were with faith-based agencies. Next year's CHALENG reports will continue to review the nature of faith-based agency participation in CHALENG.

Outcomes Reported by POCs

CHALENG POCs documented the results of their joint efforts with the community. Table 20 reports these data by VISN. VA/community partnering increased housing and treatment capacity, and secured funding for community-based homeless services as follows:

- 7215 new beds were established including:
  - 1,728 new emergency beds
  - 2,812 new transition beds
  - 2,675 new permanent beds.
- 2,061 new treatment program slots were developed.
- $95,665,448 in new grant money was awarded.

Table 20. Housing, Treatment and Grant Outcomes by VISN Through the CHALENG Process (FY 2002).

VISN	Number of Emergency Beds	Number of Transition Beds	Number of Permanent Housing Beds	Number of Treatment Slots	Grant Funds Awarded
1	55	140	171	41	$5,293,000
2	18	72	15	100	$8,789,870
3	408	326	461	116	$934,885
4	0	97	135	124	$5,817,405
5	140	40	0	55	$950,000
6	35	153	33	122	$176,040
7	0	134	0	70	$1,978,363
8	0	104	101	32	$3,312,864
9	40	212	0	40	$5,211,757
10	100	115	880	20	$5,628,374
11	48	92	32	116	$8,791,676
12	0	28	12	20	$7,959,437
15	0	36	97	9	$2,958,958
16	22	68	136	333	$5,388,067
17	88	90	80	92	$11,110,977
18	0	163	35	86	$3,823,655
19	40	90	0	25	$319,000
20	79	73	77	96	$1,628,500
21	270	332	182	449	$9,180,052
22	180	405	40	90	$1,697,373
23	205	42	188	25	$4,715,195
Totals, All VISNs (2002):	**1,728**	**2,812**	**2,675**	**2,061**	**$95,665,448**
Totals, All VISNs (2001):	**2,471**	**3,193**	**2,339**	**2,927**	**$65,247,351**

Compared to FY 2001, FY 2002 saw decreases in the number of new housing and treatment slots developed with the exception of the number of permanent beds, which saw a slight increase in new units. Also, 2,061 treatment program slots were developed, a decrease from the number of new treatment slots (2,927) created in FY 2001.

Reported new grant funding for FY 2002 was $95,665,448– a 47% increase in the amount of new grant funding secured compared to FY 2001 ($65,247,351). Table 21 identifies the main grant funding sources for FY 2002.

Table 21. Sources of New Grant Funding for FY 2002.

Grant Source	Amount
VA Grant and Per Diem Funding	$7,844,690
VA Per Diem Only	$4,053,601
HUD	$55,485,766
Other Funding Sources	$28,281,391
Total:	$95,665,448

HUD funding represented about 66% of all new funding with VA Grant and Per Diem and VA Per Diem Only funding representing 10% of new money. About 24% of new

grant funding came from "Other" sources including Community Development Block Grants (CDBG's), local counties, United Way, and foundations.

FY 2001 Funding and FY 2002 Housing Increases

Last year's CHALENG report raised the question of whether new 2001 funding would translate into new housing increases in FY 2002 and subsequent years. To explore this, we examined: (1) whether sites that received new VA Grant and Per Diem (GPD) funding in 2001 were more likely to report any new transitional housing beds in 2002 (compared to sites that received no new funding) and (2) whether sites that received new HUD funding in 2001 were more likely to report any new permanent housing beds in 2002 compared to sites who received no new HUD funding. (VA funds and HUD funds are used to create/secure transitional housing and permanent housing respectively.)

Table 22. Association Between New Grant and Per Diem Funds in 2001 and New Transitional Housing Beds in 2002.

	Sites that Reported New Transitional Housing in 2002[+]	
	Yes	No
Received new Grant and Per Diem funds in 2001	62%	38%
Did not receive new Grant and Per Diem funds in 2001	54%	56%

[+]Chi-Square: n/s

Table 23. Association Between New HUD Funds in 2001 and New Permanent Housing Beds in 2002.

	Sites that Reported New Permanent Housing in 2002*	
	Yes	No
Received new HUD funding in 2001	50%	50%
Did not receive new HUD funding in 2001	29%	71%

*Chi square ($p<.05$)

Although a higher percentage of sites that received new GPD funding in 2001 indicated new transitional housing in 2002 compared to those with no new GPD funding (62% vs. 54%), this difference was not statistically significant. There are two possible reasons for this lack of differences between sites. First, it may take time to create transitional housing, so the full impact of the new VA funding is still not measurable a year later. Also, sites that did not obtain new VA funding for transitional housing may have received transitional housing funding from other sources.

Table 23, however, documents a statistically significant relationship between receiving HUD funding in 2001 and creating new permanent housing in 2002. Fifty percent (50%) of sites with 2001 HUD funding reported new permanent housing in 2002 compared to only 29% of sites with no 2001 HUD funding. This finding may reflect the impact of new HUD funding on creating new housing capacity for homeless veterans.

With two straight years of large increases in reported overall new funding (a 47% increase between FY 2002 and FY 2001, a 215% increase between FY 2001 and FY 2000), it will be important to see whether this corresponds with new housing beds in the

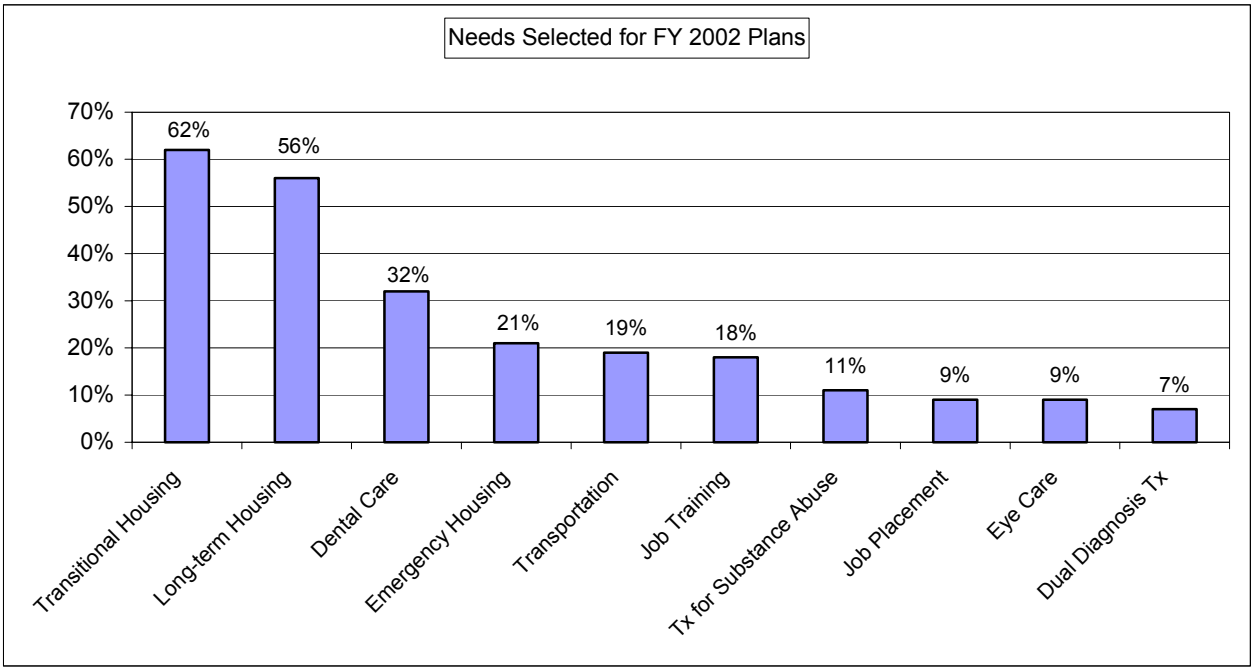
coming years. Future CHALENG reports will continue to monitor new funding in relation to housing.

POC Action Plans

POC Success in Executing FY 2002 Action Plans

As part of the CHALENG survey in FY 2001, POCs were asked to select the three highest priority needs in their areas and to indicate how they would address these needs in FY 2002 by submitting written plans. The most frequently selected needs to address were housing (transitional, long-term, permanent, emergency), dental care, transportation, job training and placement, substance abuse treatment, eye care and dual diagnosis treatment (see Figure 1).

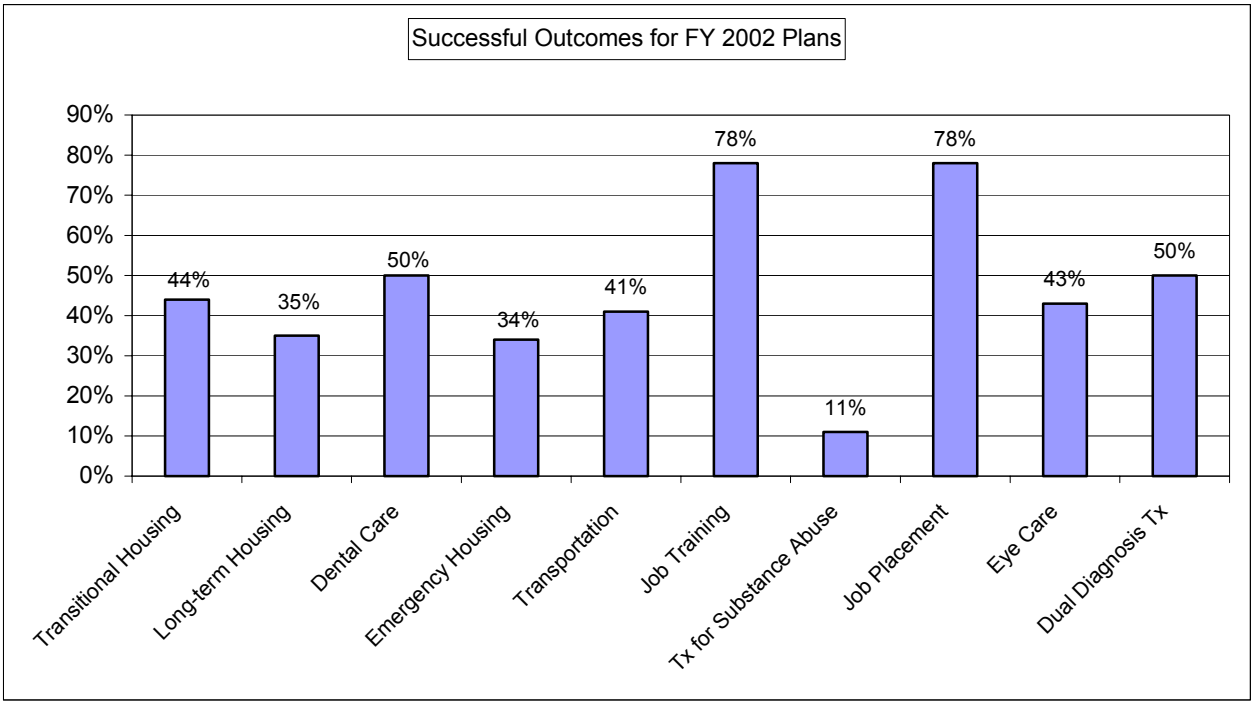
Figure 1. Top Needs Selected for Points of Contact to Address for FY2002.



For this CHALENG report, POCs were asked to indicate their success in implementing their plans to meet the top three needs that were identified. (See Appendix 7 for all POC progress reports.) For the purposes of this report, success was defined as achieving tangible outcomes such as securing additional transitional housing beds, negotiating a reduced/free bus fare for homeless veterans, or receiving grant funding for a project. Success did not include the beginning of processes that may eventually lead to accomplishments such as starting initial planning or submitting a grant for funding.

Figure 2 shows the percentage of sites that were successful in obtaining an outcome for the ten most frequently selected needs to address in FY 2002.

Figure 2. Outcomes for Top Ten FY 2002 Action Plan Topics with Percentages of POC Sites that were Successful.



Here are some examples of how POCs achieved success in addressing their priorities for FY 2002:

- Long-term, permanent housing: Additional Section 8 vouchers made available to veterans; new apartments constructed; new contracts made with agencies providing permanent housing; new funding for permanent housing secured through HUD.
- Transitional housing: Opened transitional housing units; established new contracts with transitional housing providers; secured VA Grant and Per Diem funding and HUD funding.
- Dental care: Secured state and local foundation money for dental services; obtained reduced rates from local providers and university dental school.
- Emergency housing: New local shelters opened and existing shelters expanded; obtained funding to pay for shelter beds.
- Transportation: Purchased vans; shared vans with local community agencies; obtained bus tokens/bus passes from local government.
- Job training/job placement: Contracted new vocational staff; implemented Incentive Therapy and Compensated Work Therapy Programs; partnered with local (county agencies, private nonprofit agencies) employment training programs; received Department of Labor Homeless Veterans Reintegration Project funding.
- Substance abuse treatment: Contracted with local community treatment program.
- Eye Care: Received funding from state Department of Veterans Affairs; located less-expensive provider for eye care in community for veterans.

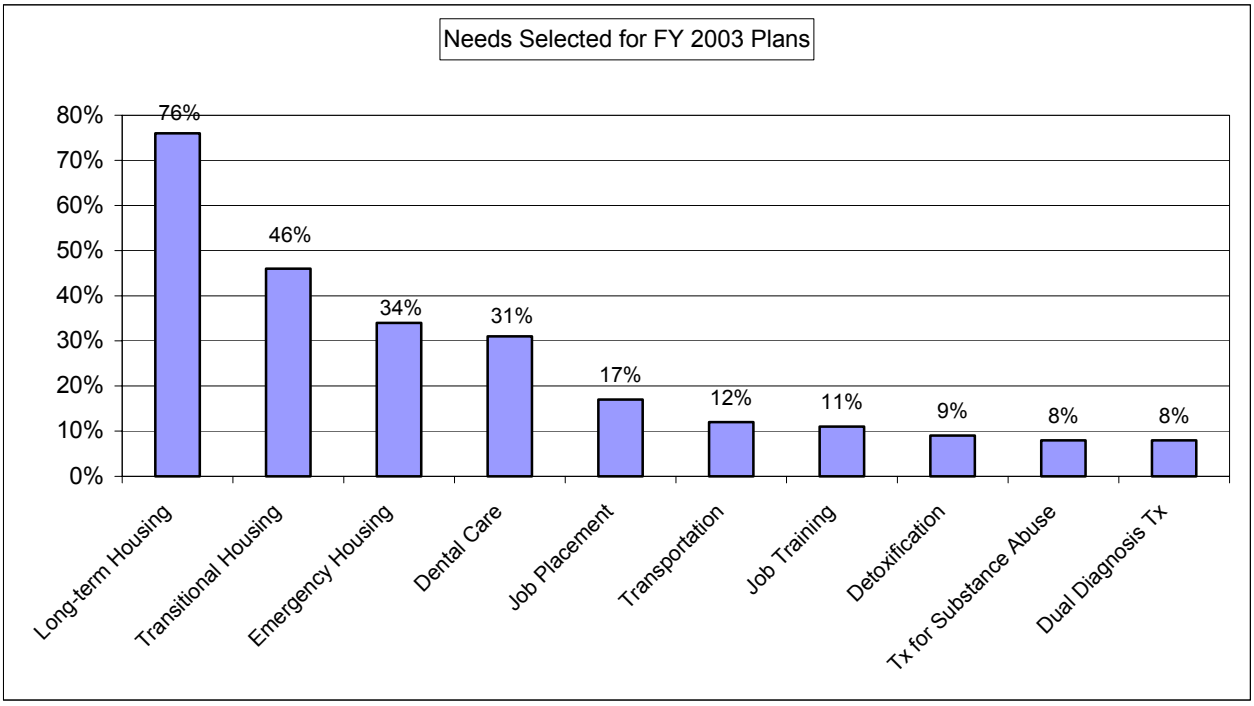
- Dual Diagnosis Treatment: Improved service coordination between VA mental health and drug abuse treatment programs; hosted dual diagnosis group at local community agency; started dual diagnosis track at VA domiciliary.

Most commonly, POC sites that did not achieve success with their FY 2002 plans mentioned lack of funding (grant proposals denied, loss/reduction of existing program funding) as a factor.

POC Action Plans for FY 2003

The 2002 POC survey requested that POCs outline their action plans for addressing top unmet needs of local homeless veterans in FY 2003. Frequent unmet needs addressed in the plans generally mirrored those selected in FY 2002 and included: housing (emergency, transitional, and permanent), dental care, transportation, jobs, substance abuse treatment, and dual diagnosis treatment. This year, however, detoxification replaced eye care as one of the top ten needs selected by POCs to work on (see Figure 3 below).

Figure 3. Top Needs Selected for Points of Contact to Address in FY 2003 Action Plans.



In the Participant Survey, community participants were asked to name the top three greatest unmet needs in their communities that they would like to address in FY 2003. Importantly, the five most mentioned unmet needs were the same five needs most frequently identified in POC plans for FY 2003: long-term, permanent housing, transitional housing, emergency housing, dental care, and job placement.

Summary

The annual CHALENG Survey documents needs of homeless veterans identified by veterans, community agencies and VA staff. CHALENG also records how VA and community agencies work together to plan and meet those needs.

The FY 2002 Report indicates that some key needs – long-term housing, dental care, eye care, and child care – continue to be pressing issues for homeless veterans. On the positive side, initiatives like limited VA dental coverage for veterans in homeless programs (VHA Directive 2002-080) and an infusion of HUD monies bring new resources to bear on these chronic problems. New housing, treatment, dental, eye care, and child care resources continued to be developed in FY 2002. Further, VA and community agencies seemed to be collaborating more through such activities as forming interagency agreements, developing joint client tracking systems, and creating special waivers to facilitate improved veteran access to services.

Excitingly, a higher number of homeless and formerly homeless veterans were involved this year in the CHALENG process. Faith-based organizations were also well represented. Efforts to help homeless veterans are enhanced when all segments of a community are engaged.

The report also clearly indicates that much work still remains in assisting homeless veterans out of homelessness. CHALENG will continue to identify progress of the VA and the community toward that goal.

References

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